REPORT OF THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES ON

Access to Psychiatric Care for Jail Inmates

Item 329K: 2002 Appropriation Act

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Executive Summary: Access to Psychiatric Care for Jail Inmates: Item 329K

This study was completed in response to the directive to the Department of Mental Health, Mental Retardation and Substance Abuse Services in Item 329 K#9c of the 2002 Appropriations Bill:

"By budget amendment, direct the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), in consultation with the Department of Corrections, Virginia Sheriffs' Association, the Regional Jails Association, and the Virginia Association of Community Services Boards (VACSB) to make recommendations to this committee concerning access to psychiatric care for jail inmates including the availability of inpatient beds, judicially ordered treatment, and atypical anti-psychotic medications. The recommendations should include consideration for use of existing state facilities (Department of Corrections and DMHMRSAS) and designated sections of regional jails."

The work group reviewed the range of current standards and practice for the provision of mental health and substance abuse services in local and regional correctional facilities in Virginia. The five basic agenda items addressed by the work group included: Access to psychiatric care for jail inmates; the availability of inpatient beds; judicially ordered treatment; availability of atypical antipsychotic medication for treatment of jail inmates; the use of vacant DOC or DMHMRSAS facilities, or portions of regional jails for treatment of jail inmates with mental illness and substance abuse disorders.

It was determined from review of several legal, clinical and accreditation sources that current practice standards mandate the provision of several basic elements of mental health and substance abuse treatment for jail inmates. These basic services include, at a minimum:

- Intake screening at booking
- Evaluation following screening when needed
- Use of the full range of appropriate psychotropic medication
- Substance abuse counseling
- Counseling services
- The availability of emergency hospitalization
- Case management services

The extent to which these basic services are provided in local and regional jails in the Commonwealth of Virginia was examined by the work group in its meetings, and via review of the results of two surveys of jail mental health and substance abuse service provision that were completed for the Senate Joint Resolution 440 Study Committee, in 2001, along with data obtained from other sources.

The work group concluded that efforts at facilitating MH/SA service provision in jail settings should take place within the context of an overall strategy for change that includes efforts at diverting nonviolent, mentally ill and substance dependent individuals

from incarceration whenever appropriate. Based upon the data, it was found that while many basic MH/SA treatment services are available in all or nearly all jail settings, there is some degree of unmet need for such services in the jails of the Commonwealth. The work group recommended that additional study of this issue should be completed to verify the actual levels of current need.

The work group also examined hospital bed availability for emergency treatment of jail inmates and non-emergency evaluation and treatment services. Referrals from jails for emergency hospitalization to state facilities are typically completed without major impediment, and in a timely manner; although some cases reportedly require additional wait times, prior to admission. Some delays occur with the admission of those who have been court-ordered to state hospitals for non-emergency evaluations and treatment.

The question of whether or not there is a need for the courts to have the capability to authorize involuntary treatment for jail inmates was addressed by the work group. It was verified that there are already several ways by which courts may order involuntary psychiatric treatment for jail inmates. It was also found that the *Code of Virginia* currently empowers the courts of the Commonwealth to order involuntary treatment with antipsychotic medication for individuals who are not competent to provide informed consent, provided that the individual has already been committed to the DMHMRSAS by the courts. Work group members also reported that the majority of inmates needing psychotropic medication in jails readily consent to such treatment. Those that do not are referred to state hospitals for that treatment, in conformance with the requirements of the *Code*.

Additionally, the work group reviewed the use of atypical antipsychotic medications in local correctional facilities. It was reported by work group representatives from the Virginia Sheriffs' Association and the Virginia Regional Jails Association that, despite earlier reports to the contrary, jail medical services routinely provide atypical psychotropic medications to jail inmates who are in need of such medical care. The high cost of providing treatment with "atypicals" was cited as an area of concern. Additional verification of the availability of atypical medications was also recommended.

The work group considered the use of existing but currently vacant DOC or DMHMRSAS facilities as sites for providing specialized care for jail inmates with mental illness or substance abuse disorders, along with the recommendation that portions of regional jails might be set aside for mental health and substance abuse treatment purposes. While it was determined that the use of vacant DOC or DMHMRSAS facilities is not currently a viable option for enhancing service provision for inmates with mental illness and substance abuse disorders, the concept of designating portions of currently operational units or housing areas of large regional jails for use as regionalized Mental Health and/or Substance Abuse treatment programs was determined to have some potential value.

The development of such specialized regional facilities would allow for all jails to have potential access to an enhanced level of jail-based mental health and substance abuse treatment services, using a referral approach similar to the process that is currently used for state hospital admissions. Considerable savings in costs could be realized by such an approach, relative to the costs of psychiatric hospitalization; such an approach would also further facilitate the expeditious provision of treatment services to jail inmates.

While the provision of additional services for jail inmates with mental illness and substance abuse disorders will require the use of additional fiscal resources if all of the identified service needs are to be fully met, any efforts toward the goal of improved access to MH/SA services in the jails should take place within the context of a systems model for service provision. A model of this type should encompass the delivery of community-based diversion efforts, jail-based treatment, and the use of state facilities within a comprehensive framework of service delivery that allows for the consideration of resource allocation from the perspective of optimum utilization.

The continuum of care that begins in the community, continues in jail, and progresses to inpatient psychiatric treatment often involves a progressive, sometimes exponential increase in costs with each successive step. A sound model for improving the access to mental health and substance abuse treatment services for offenders would allow for the containment of the costs of service delivery by providing appropriate levels of treatment in the least costly and, in many instances, less restrictive, shorter term setting.

Report of the SJR 97/HJR 142 Workgroup Studying Access to Psychiatric Care for Jail Inmates (Item 329K)

September 12, 2002

I. Introduction

In their final report *Studying Treatment Options for Offenders Who Have Mental Illness or Substance Abuse Disorders* (SD #25, 2002), the membership of the Joint Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders (Senate Joint Resolution 440, 2001) cited 5 summary findings and 14 recommended actions, regarding the mental health and substance abuse treatment needs of adult offenders. Recommendation #4 regarding problems with the current capacity of the mental health/substance abuse system to manage offenders with mental illness and substance abuse disorders, stated:

"By budget amendment, direct the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), in consultation with the Department of Corrections, Virginia Sheriffs' Association, the Regional Jails Association, and the Virginia Association of Community Services Boards (VACSB) to make recommendations to this committee concerning access to psychiatric care for jail inmates including the availability of inpatient beds, judicially ordered treatment, and atypical anti-psychotic medications. The recommendations should include consideration for use of existing state facilities (Department of Corrections and DMHMRSAS) and designated sections of regional jails."

The activity of the SJR 440 study committee has been continued during 2002 by the Joint Committee authorized by SJR 97/HJR 142. This report has been prepared for submission to the Chairmen of the House Appropriations Committee and the Senate Finance Committee, in response to Item 329K of the 2002 Appropriation Act.

Study Process

Two meetings of the work group were convened on August 8, 2002 and August 20, 2002. The membership of the work group consisted of representatives from the following organizations:

- Department of Mental Health, Mental Retardation and Substance Abuse Services
- Department of Corrections
- Virginia Association of Community Services Boards
- Virginia Association of Regional Jails
- Virginia Sheriffs Association

The work group members reviewed each of the agenda items mandated by the study directive during two extended sessions. In addition, all work group members contributed additional information to the completion of the study report.

II. Background

1. Mental Illness and Substance Abuse Disorders in Local Correctional Settings: A National Problem

Much has been written in the past 15 years regarding the problems of the mentally ill and substance dependent individuals who are housed in local and regional jails in the United States. The oft-quoted figures from the Bureau of Justice Statistics (BJS, 1999) estimate that more than 16 percent of all jail inmates, or a total of 96,700 had significant problems with mental illness, according to 1998 figures from the National Prisoner Statistics and Annual Survey of Jails. Of that group, only approximately 40 percent of all jail inmates reported that they had received any form of psychiatric treatment since admission. Medication treatment was the most prevalent modality received (34%); less than half received counseling services, according to the BJS report. The 1999 BJS report also stated that roughly 50 percent of all inmates had been actively involved with drug or alcohol abuse in the month prior to incarceration in 2000. More recently (BJS, 2000), it was reported that 65 percent of all jail inmates sampled indicated that they had used drugs other than alcohol in the month prior to incarceration. Comparison of these figures verifies that the population of mentally ill inmates in jails is far exceeded by those with active substance abuse.

Given the magnitude of these problems, there has been a pressing need for the development of parameters and standards for the ethical provision of care to jail inmates having mental illness and/or substance abuse problems. During the past decade, the increase in academic and applied research directed at defining the parameters of clinical service provision in the areas of mental health and substance abuse treatment for offenders has yielded evidence-based practice guidelines for the establishment of proper treatment programs in jail settings. Additionally, professional accreditation organizations have established certification standards for medical care in jails that include psychiatric service provision. Finally, significant changes in the laws that relate to jail incarceration procedures have also defined the mandatory parameters for provision of treatment services in jail settings in the United States.

2. The Legal Basis for Provision of Mental Health and Substance Abuse Services in Jails

A comprehensive analysis of the current legal basis for the provision of mental health and substance abuse services was provided to the Committee Studying Treatment Options for Offenders Who Have Mental Illness or Substance Abuse Disorders (Wallace, 2001). These requirements have also been summarized in several other sources, including Cohen (1998), Dvoskin (1992), and the National Institute of Corrections (2001). In his report to the Committee, Wallace presented the following key findings:

- "The Eighth Amendment prohibition against "cruel and unusual punishment" requires that anyone in criminal custody who suffers from a mental illness be given medical treatment for any serious" illness.
- Rehabilitation for a substance abuse disorder does not meet Eighth Amendment standards for inclusion as a necessary treatment. (According to the Wallace report, Virginia law requires that substance abuse treatment be available in correctional settings.)
- The provisions of the Americans with Disabilities Act (ADA) may be applicable to the needs of those with mental illness or substance abuse disorders to treatment in jails.

Cohen (1998; 2001) has written extensively on the legal aspects of correctional mental health care. His summary list of component elements to address in developing a mental health treatment program in correctional settings, included the following items of relevance to this study:

- Screening and evaluation to detect serious mental illness
- Reasonable access to adequate care upon admission
- Adequately trained staff in sufficient numbers
- Treatment and bed space that is sufficient for program needs
- Proper administration and monitoring of psychotropic medications
- A suicide prevention program
- A humane treatment environment
- Quality assurance and adequate maintenance of treatment records

3. Clinical and Professional Standards for Jail Mental Health and Substance Abuse Services

The American Psychiatric Association listed minimum guidelines for the provision of jail mental health services in 1989, and again in 2000 (American Psychiatric Association, 2000). Those guidelines included: Routine and universal mental health screening at booking; follow-up, in-depth assessment for those in need within 24 hours of booking; a full-scale psychiatric evaluation when necessary; crisis intervention; access to short-term (medication) treatment; inpatient care, when necessary; discharge/release planning.

Steadman and his colleagues (1989) provided the following list of mental health services that should be provided in local correctional facilities:

- Intake screening at booking
- Evaluation following screening
- Use of psychotropic medication
- Substance abuse counseling
- Competency assessment

- Psychological therapy
- External hospitalization
- Case management services

Several correctional accreditation organizations have also defined the provision of mental health care as a component of required medical services in jails. These organizations, which include the American Correctional Association (ACA), the American Public Health Association (APHA), the National Commission on Correctional Healthcare, and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) have focused primarily upon the need for including mental health screening and assessment procedures as part of inmate medical evaluations. Additionally, the standards set by these organizations encourage the protection of disabled inmates from harm, and the provision of all necessary medical care, including psychiatric treatment. The provision of substance abuse treatment is also included in some of the accreditation standards.

III. An Overview of Mental Health and Substance Abuse Treatment Services in Virginia Local and Regional Jails

1. Access to Psychiatric Care for Jail Inmates

The various sets of legal and clinical standards for jail mental health services summarized above provide a solid framework or template for measuring the extent to which jails in the Commonwealth provide services that accord with nationally endorsed norms. For this study, the work group reviewed the results of an existing report for that comparison. In 2001, the Committee Studying Treatment Options for Offenders Who Have Mental Illness or Substance Abuse Disorders (SJR 440) authorized a survey of local and regional jails. A total of 75 local sheriffs and regional jail superintendents in Virginia were surveyed to assess the incidence of mental illness and substance abuse problems among jail inmates, and the amount of mental health and substance abuse treatment services that were provided in the jails. With 80 percent of those surveyed responding, the majority reported that at least 16 percent of jail inmates were in need of active psychiatric care.

The 2001 SJR 440 survey results are summarized in part in Table 1. In accord with the established and recommended standards described in the preceding section, those responding to the survey reported a high level of activity with the screening and assessment of jail inmates on admission. A total of 96.7 percent of those surveyed reported that inmates are screened for mental health treatment needs upon admission. A standardized screening instrument was used for that screening 80.4 percent of the time. Nearly 97 percent of the survey responders verified that inmates manifesting mental health problems when screened are subsequently seen for a more comprehensive mental health assessment. About 40 percent of these assessments made use of a standardized instrument or approach.

Table 1: Mental Health and Substance Abuse Treatment Services in Virginia Local and Regional Jails: SJR 440 2001 Survey		
MH Service Category	**% of jails with service**	**% of jails w/o service**
MH/SA admission screening	**96.7**	**2.3**
Assessment when needed	**96.6**	**3.4**
Emergency/Crisis Intervention	**100 (M); 98.1(F)***	**0.0(M); 1.9(F)**
Medication Treatment	**76.3(M); 77.8(F)**	**23.7(M); 22.2(F)**
MH Individual Counseling	**76.3(M); 75.9(F)**	**33.7(M); 24.1(F)**
Case Management	**62.7(M); 61.1(F)**	**37.3(M); 38.9(F)**
Group Counseling	**35.6(M); 41.5(F)**	**64.4(M); 58.5(F)**
SA Service Category		
SA admission screening	**86.7**	**13.3**
Follow-up Assessment	**84**	**16**
Emergency/Crisis Intervention	**77.2(M); 73.6(F)**	**21.1(M); 24.5(F)**
Medication Treatment	**50.9(M); 49.1(F)**	**45.6(M); 47.2(F)**
MH Individual Counseling	**66.7(M); 64.2(F)**	**29.8(M); 32.1(F)**
Case Management	**52.6(M); 51.9(F)**	**43.9(M); 44.2(F)**
Group Counseling	**70.2(M); 73.6(F)**	**26.3(M); 22.6(F)**

* (M)=males; (F)=females

The data presented above from the SJR 440 study show that screening for symptoms of mental illness and emergency assessment and treatment services were reported to be fully available in the jails reported on by survey respondents. From about two-thirds to three quarters of the jails surveyed offered other forms of treatment for mentally ill inmates. Fewer jails had emergency and medication services available for inmates with substance abuse disorders. In light of the standards reviewed above, the most noteworthy finding from the SJR 440 study was the high percentage of jails that reported that one or more types of clinical services were not available at their sites.

A complimentary set of data was obtained from the results of another survey completed by the DMHMRSAS in 2001 (Kellogg, 2001). The DMHMRSAS survey data were provided by 34 (70%) of the 40 Virginia Community Services Boards (CSBs), reporting on 78 local and regional jails (86%) throughout the state. The reporting period for the survey data was from November 1, 2000 to April 30, 2001. Projecting the data from the jails surveyed to the entire jail population, the DMHMRSAS survey estimated that, for the 6 month period studied, a total of 11,800 jail inmates did not receive needed mental health or substance abuse services. While the report of that survey "broke out" those served or not served by type of treatment service in some detail, it is sufficient to note here that while only an estimated 19 percent of mentally ill jail inmates needing emergency mental health services statewide did not receive them, the amount of estimated unmet need for other mental health and substance abuse treatment services was

much greater. However, two vital services, medication management and case management were notably available to many jail inmates during the period sampled by the survey.

The results of the 2001 survey completed by the DMHMRSAS also indicated that there was generally a positive correlation between the size and population of a local or regional jail, and the amount of mental health and substance abuse services provided. Smaller local jails typically did not report sufficient demand or need for these services to allow for the establishment of a dedicated unit or special staff to provide these treatment services.

Examples of larger scale programs in Virginia that have a full complement of mental health and substance abuses services available, including self-contained units for housing and treating mentally ill inmates, are the Arlington and Fairfax Jails. Each of these jails has a full array of on-site services available. These and other large-scale jail programs also have self-contained substance abuse programs. These "Therapeutic Communities", which are supported by federal grant programs, also provide a similar array of therapeutic interventions for those with substance abuse disorders that are available in the Arlington and Fairfax programs for the mentally ill inmates.

❖ ***Finding 1:*** *Access to psychiatric services in jails*

Review of the developing national standards for mental health and substance abuse treatment identified that a core set of services, including MH/SA screening and assessment, emergency treatment, psychotropic medication treatment, substance abuse counseling, and case management may be expected to be in place in all local and regional jails in the United States. The available legal information reinforces this conclusion, both on the basis of constitutional protections and with regard to tort liability.

The SJR 440 and DMHMRAS surveys, while providing only estimates, offered convincing "first blush" evidence that the mental health and substance abuse treatment needs of jail inmates in Virginia are yet to be fully addressed. CSBs and jail health services do provide a substantial array of mental health/substance abuse services in many jails in Virginia. These findings were made by the work group:

- The evidence reviewed by the group verified that mental health and substance abuse screening services to inmates admitted to local and regional jails are provided in the majority of jails, in a manner that accords with national standards.

- The majority, but not all of local and regional jails in the Commonwealth provide in-depth mental health and substance abuse assessments, when such assessments are indicated by the results of admissions screenings.

- Access to emergency mental health screening for treatment and hospitalization is available to jails in all areas of the Commonwealth.

- There is a need for additional service provision in many jails in the Commonwealth, including such essential treatments as psychotropic medication, case management services, and group and individual counseling for mentally ill inmates and those with substance abuse disorders.

➢ ***Recommendations:***

The work group did not formulate recommendations for specific changes in statutes or regulations. The following recommendations were developed for this part of the study:

1. The members of the work group endorsed the basic concept that, whenever appropriate, diversion of those with significant mental illness and substance abuse disorders into community-based treatment should take place in lieu of extended and unnecessary incarceration. This approach would serve to limit the amount of resources needed for jail-based services.
2. There is a need for additional study to determine the actual levels of unmet needs and to verify the current range of mental health and substance abuse service provision available in all the local and regional jails in Virginia, prior to developing programmatic changes from current practice.
3. A comprehensive plan should be developed for ensuring that requisite mental health and substance abuse services are provided to jail inmates throughout the Commonwealth.

➢ ***Estimated fiscal impact:***

It is anticipated that there would need to be a significant enhancement of currently available resources, to enable all of the local and regional jails of the Commonwealth to provide the full range of mental health and substance abuse treatment services that have been designated as minimally necessary by the medical and legal communities, and by jail accreditation organizations. In 2001, CSBs responding to the DMHMRSAS survey of MH/SA service needs in the Commonwealth provided estimates indicating that, on an annualized basis, there would need to be an additional expenditure of approximately $34,000,000 per year, to provide for the unmet MH/SA service needs in local and regional jails in Virginia.

At least some of the fiscal impact of implementing such change could be reduced by the implementation of a systems approach to the process of managing offenders with mental illness and substance abuse disorders. Use of a "front-loaded" model or approach to the improvement of service provision in this area may represent the most fiscally responsible and efficacious way to reach the goal of improving service delivery, overall.

2. The Availability of Inpatient Beds for Treatment of Jail Inmates

In addition to the overall survey results, the SJR 440 study reported the recommendation from survey respondents that there is a need for increased access to hospital beds for jail inmates in need of intensive care. The work group conducted a thorough review of the information available on the matter during its meetings. Section 19.2-169.6 of the *Code* authorizes the court to order emergency pretrial treatment for defendants in criminal proceedings. Section 19.2-176 provides for pre-sentence commitment for inmates of local and regional jails who have been convicted but not yet sentenced. Section 19.2-177.1 provides for post-sentence commitment for inmates of local or regional jails who have already been convicted and sentenced. The time interval occurring between the date that a court order is written for the admission of a jail inmate to a DMHMRSAS psychiatric facility, and the actual date of admission of the inmate to the facility was used for this study as a means to measure the average time it takes for an inmate to be hospitalized, once the court order has been written.

During FY 2002, data collected by the DMHMRSAS showed that a total of 282 jail inmates were admitted for pretrial treatment. The average waiting time for admission for inmates in this category was less than 24 hours. The maximum waiting time was 72 hours. For the 10 inmates admitted for pre-sentence treatment, a slightly longer waiting time of 2.4 days was the average, with the maximum time on the waiting list being a total of 22 days. Post-sentence wait times for the 63 jail inmates needing emergency treatment averaged less than 24 hours. No one in that category waited beyond the one-day period. The brief time periods between the date that an inmate was referred by the court for emergency treatment, and the actual admission of that inmate to a state psychiatric hospital provide evidence that there is currently sufficient access to inpatient care of this type. Based on the data available, the work group concluded that there is no current need for an increase in bed capacity at state hospitals in order to provide emergency treatment to transferred jail inmates.

The criminal courts of the Commonwealth also refer defendants to DMHMRSAS-operated facilities for purposes unrelated to any mental health problems manifested in the jail setting. These non-emergency court referrals occur mainly for purposes of:

- Evaluation of competency to stand trial (§19.2-169.1)
- Evaluation of sanity at the time of the alleged offense (§§19.2-168.1 and 19.2-169.5)
- Treatment of defendants to restore competency to stand trial (§19.2-169.2)

The Code clearly states that evaluations of competency and sanity should be community-based, if possible, and that the first choices for completion of such evaluations are in the community, or the jails. In fact, many defendants are admitted to DMHMRSAS facilities annually for completion of evaluations of this type for the courts. Using the approach summarized above for emergency treatment referrals, an assessment of wait times for admission was completed for those referred for evaluation. An average interval of approximately 18 days occurred, between the date of issuance of a court order

for a hospital-based evaluation, and the date of admission of the referred inmate to that hospital.

The work group analysis also established that admission of jail inmates referred by the courts for restoration to competency involved an average delay of about 43 days from the issuance of the court order for restoration treatment to the actual date of admission to a state mental health facility for that purpose.

Provisions have been placed in the Code (§§19.2-178 and19.2-174.1) that allow for inmates awaiting evaluations or other services to be held in local correctional facilities until a vacancy exists at a hospital, or until the proper documentation has been provided. The analysis completed by the work group indicated that there is a need to address the matter of delays in the admission of jail inmates to state facilities for court-ordered non-emergency evaluations and restoration to competency services, in addition to promoting the practice of community-based provision of these services. Given the mandated per capita staffing and resource requirements that are in force in state hospitals currently, and the additional fact that all DMHMRSAS hospitals operate at or near full capacity on a daily basis, it would not be readily possible for facilities to increase the rates of admission of jail inmates for court-ordered evaluations and restoration to competency services without a significant increase in their operational resources and bed capacities.

❖ ***Finding 2:*** *The availability of inpatient beds for treatment of jail inmates*

The work group for this study reached the following set of conclusions regarding the ability of jails and courts to obtain inpatient evaluation and treatment services for jail inmates:

- The process for securing court-ordered emergency hospital treatment is conducted in an efficacious manner in all areas. Jail inmates with acute psychiatric treatment needs are admitted for treatment without delay, in most instances.

- There is a need for review and modification of the process for completion of court-ordered evaluations of competency and sanity, in order that the waiting times required for completion of these evaluations can be reduced.

- Waiting times for the start of treatment to restore competency to stand trial should be reduced.

➢ ***Recommendations:***

The results of this study indicated that actions should be undertaken to enhance the current levels of access to inpatient treatment for jail inmates. While the work group did not recommend statutory or regulatory change, it was determined that a significant increase in resources would be needed to provide enhanced access to hospital beds for non-emergency evaluation and treatment. Community Services Boards and jails would

also have requirements for additional resources, in order to provide these services in community or jail settings. The work group offers the following recommendations:

1. In accordance with the longstanding goal of the DMHRMSAS in the area of forensic evaluation services, increased emphasis should be placed upon the use of community-based evaluators by the courts for completion of evaluations of sanity and competency with defendants. A reduction in the numbers of referrals to state hospitals for this purpose would allow for more expeditious provision of emergency treatment by those facilities. An increase in the number of community evaluators will likely be needed to manage an increased rate of referrals for community-based evaluations. Some of this increased need could be met by enabling evaluators from state hospitals to complete evaluations in the community. It will also likely be necessary for additional forensic evaluation training resources to be available, in order that additional community mental health professionals may attain skills for completing evaluations for the courts.
2. The activity of the work group should be continued for the purpose of developing a more integrated set of approaches with regard to the provision of non-emergency, court-ordered evaluation and treatment services in jails and community settings. This work may include the analysis of additional impediments to basing service delivery in the community, as well as the development of "model" approaches for improving access to community-based services of this type on a statewide basis.

- ***Estimated fiscal impact:***

The community-based approach to the provision of court-ordered evaluations that was put in place by the DMHMRSAS more than twenty years ago has been phenomenally successful in reducing the need for psychiatric hospitalization of criminal defendants for that purpose. It is estimated that the savings in hospital expenses realized from this program has ranged into many millions of dollars. While the current rate of reimbursement by the Virginia Supreme Court for an outpatient evaluation of competency to stand trial is $300.00, for instance, referral of a defendant to a state psychiatric facility for this procedure typically results in a 30 day hospital stay for the defendant. The cost for 30 days of hospitalization is typically greater than $15,000. The During FY 2002, there were 122 admissions to state hospitals for evaluations of competency and/or sanity.

Given the average 30-day length of stay for patients in this group, the cost for these inpatient evaluations approaches $2 million. The cost for completing 122 of the same evaluations in the community would be far less than $100,000. Even when the per diem cost for housing a defendant in a local correctional facility is included, it is estimated that the cost of hospital-based evaluations approaches four times the total amount required for the completion of forensic evaluations of criminal defendants in jail settings.

While not all jail inmates admitted for evaluations can be readily assessed in community settings, it is evident that even a 25% decrease in admissions per annum for this purpose would represent a significant savings in hospital treatment expense. Savings of this caliber, redirected in the proper manner, could help to generate much greater capacity for community-based initiatives, for all those with mental illness and substance abuse disorders in the community, as well as for those with such disorders who have criminal justice system involvement.

Further enhancement of this community-based approach for forensic evaluation services may require the expenditure of some additional resources for training of evaluators, and for reimbursement of community providers for such evaluations. The savings realized with such an approach would far outweigh the expenditures required to perform hospital-based evaluations. Additionally, the further development of ongoing efforts to provide community-based treatment for restoration to competency to stand trial for criminal defendants should also provide a cost-effective alternative to inpatient treatment for this purpose.

The work group concluded that addressing the goal of reduced waiting times for admissions to state hospitals for non-emergency evaluations and treatment by increasing state hospital beds would represent a considerable expense.

3. Judicially-Ordered Treatment

Reviewing this topic, the work group assessed the value of enabling the courts of the Commonwealth to order the provision of mental health and substance abuse treatments in local and regional correctional facilities. Delays occur with certain types of hospital admissions other than emergency treatment, and there are some jail inmates with chronic psychiatric conditions who do not meet the criteria for emergency involuntary hospital admission. Therefore, the work group examined how to provide the full range of treatment options, on a voluntary or involuntary basis, within jail settings.

The group discussed current procedures with jail inmates in need of involuntary psychiatric treatment. Constitutional protections prohibit the imposition of involuntary medication treatment on individuals who are considered mentally competent. In general, however, jail inmates routinely consent to voluntary treatment with psychotropic medications, including antipsychotic medication.

According to representatives from the Virginia Sheriffs' Association, and the Virginia Association of Community Services Boards, more than seventy-five percent of jail inmates who are in need of such medications in jail consent to such treatment. It is the minority of inmates who refuse such care. As jails are required and authorized to provide necessary medical care to inmates, and given that psychiatric treatment is a medical service, treatment of consenting inmates by licensed physicians and mental health professionals does not require specific court authorization in order to occur, whenever the inmate seeks or consents to such care.

Section 37.1-134.21 of the Code allows the courts to authorize the provision of specific treatment for a mental or physical disorder, if it is found that the person is incapable of making an informed decision or unable to communicate such a decision, and it is in the best interests of the individual to provide the proposed treatment. This section of the Code also requires that an individual subject to such an order must also be subject to an order for involuntary commitment.

❖ ***Finding 3:*** *Judicially-ordered treatment for jail inmates*

In its review of the current process for the involuntary treatment of acutely mentally ill jail inmates who are not legally competent to consent to treatment with psychotropic medication, the work group determined the following:

- The current medical procedures that are available for psychotropic medication treatment of jail inmates are sufficient and appropriate for most cases, except for those in which a mentally ill and incompetent inmate refuses to consent to such treatment.
- While the *Code* provides for emergency authorization of involuntary medication treatment, that treatment can only occur when an inmate is also subject to an existing or simultaneous involuntary commitment order.
- Jail inmates who are in need of treatment with psychotropic medication, and who are not competent to consent to such treatment, may be committed by the courts for involuntary psychiatric hospital treatment. Authorization for treatment of an incompetent patient may then be sought from the court by the treating hospital.

➢ ***Recommendations:***

The work group review of this matter did not indicate that there was a need to change the current process for obtaining access of jail inmates to mental health and substance abuse treatment. However, the work group recommends that:

1. Any needed training should be provided to Community mental health and substance abuse treatment providers, as well as jail administrators to ensure that those providing mental health and substance abuse treatment services to jail inmates have access to the information necessary to obtain required treatment for jail inmates who are in need of treatment, but are unable to provide informed consent. The DMHMRSAS is submitting recommendations in another report on Cross-training and Dissemination of Innovative Practices.

➢ ***Estimated fiscal impact:***

The on-site availability of all forms of needed treatment for jail inmates with mental illness and substance abuse disorders can be expected to have a significant cost saving impact, when the cost of providing these services in jail settings is compared to the costs required to provide the same services in state hospitals. The per diem cost for

hospitalization of a jail inmate for treatment of mental illness or a substance abuse disorder is typically in the range of five to six times that the daily cost of housing an inmate in a local or regional correctional facility. Additionally, the extra time that is often required to complete treatment off-site at a hospital has the added financial and social cost of prolonging an inmate's time in custody, in many instances.

4. The Availability of Atypical Antipsychotic Medication Treatment in Local and Regional Jails.

The members of the work group agreed that there have been many anecdotal accounts circulated in which it has been alleged that contract medical services providers in jails around the Commonwealth have refused to provide prescribed antipsychotic medication to jail inmates who have been returned to custody following hospitalization, or have had such medication prescribed by a community physician, if the prescription was for an "atypical" antipsychotic medication. These accounts, which have not been verified, have indicated that it is the high cost of such medications that has caused jail medical services contractors to eliminate them from their formularies. Other accounts have blamed this purported lack of medication availability on other causes, such as use of "out-of-state" formularies.

The work group analysis of this issue determined that, in fact, the prescribing of atypical antipsychotic medication is significantly more costly than administration of "traditional" medications in this category. Information provided by the DMHRMSAS Aftercare Pharmacy, and by other sources validated that a month's supply of one of the currently used proprietary atypical agents can range in cost from $338.00 to $451.00. In contrast, a month's supply of a traditionally prescribed generic antipsychotic agent is likely to cost no more than $20.00 to $30.00. Cost differentials such as these can certainly provide incentives to limit the use of pricey "atypical" antipsychotic medications, when provision of such treatments is not mandatory.

The work group members representing the Virginia Sheriffs' Association and the Virginia Association of Regional Jails verified that atypical antipsychotic medications are routinely available and prescribed in jail settings throughout the Commonwealth. Additionally, Dr. James Evans of the DMHMRSAS, the psychiatrist consultant to the work group, indicated that any physician assigned to provide medical care, including treatment with antipsychotic medications in jail settings, is bound by professional competency and ethical standards to prescribe only those treatments which are appropriate and effective for each patient's diagnosed disorder. As with other medical and mental health professionals, physicians are required to complete continuing education, and to adhere to current standards of practice in their work. Therefore, there are some grounds for concluding that the current medical practice with administration of antipsychotic medication in jail settings conforms to the standard parameters of practice in other community settings.

❖ ***Finding 4:*** *Availability of atypical antipsychotic medication treatment in local and regional jails.*

The work group made the following determinations regarding this matter:

- The current prescribing practice in most, if not all jails in Virginia includes adequate access to atypical psychotropic pharmaceuticals, according to the information available to the work group.
- It was also the finding of the work group that provision of atypical antipsychotic medications in jails involves a considerably greater per capita expense than does administration of more traditional forms of antipsychotic medication.

➢ ***Recommendations:***

The work group did not propose specific changes in statute or regulation to address this issue. However, the following recommendations were made:

- The work group should review the formal standards (e.g., American Correctional Association; National Commission on Correctional Health Care) of quality for jail medical services providers, to ensure that all jail medical services have the full range of psychotropic medications available for the proper treatment of their clientele.
- The interagency work group should study this matter further, in conjunction with any comprehensive effort to enhance service provision in local and regional correctional facilities.

➢ ***Estimated fiscal impact:***

In the event that there is a need for additional availability of atypical psychotropic pharmaceuticals in the local and regional jails in Virginia, it is likely that there will be some immediate increase in costs for supplying jails with these medications. The fact that these atypical agents are recognized to provide more effective and expeditious symptom reduction with treated individuals than do the more traditional agents suggests that the initial costs of ensuring the availability of such medications in jails in Virginia will be more than offset by the reduction in need for additional staff and security provisions that is realized by their use.

5. Use of existing state facilities (DOC and DMHMRSAS) and designated sections of regional jails.

The work group reviewed the potential for using existing, currently vacant facilities owned by the Virginia Department of Corrections or the DMHMRSAS, for additional treatment space for mentally ill or substance dependent jail inmates. Exploration of the concept of developing regionalized, freestanding programs for

mentally ill and substance dependent individuals within regional jail settings was also included in this agenda item.

The work group considered the viability of these proposals within the context of the other aspects of this study. The courts, communities, jails and hospitals are routinely involved in the process of incarceration, assessment and treatment of jail inmates with mental illness or substance dependence problems. In this system model, treatment provided in the community is the least restrictive and typically most cost-effective. Treatment provided in jail settings, while involving a greater degree of restriction, may be more expeditious and economical than that provided at the state hospital level.

The work group also reviewed the comprehensive comparative model of service provision to mentally ill and substance dependent jail inmates which has been developed by the Human Services Research Institute (HSRI; 2002), to assess the potential value of placing access to a greater amount of treatment services at "lower" levels in the treatment system process. In this "hydraulic" approach, any mental health or substance abuse treatment that is provided in jails would likely reduce the use of more costly hospital-based care, and could, if needed, decrease the demand for scarce inpatient treatment beds.

In its discussions, the work group noted that in addition to the relative scarcity, it typically costs approximately 4 to 5 times more to treat a jail inmate in a state hospital than to house (and treat) an inmate in a local or regional jail.

❖ ***Finding 5:*** *Use of existing state facilities and designated sections of regional jails.*

The work group made the following findings, regarding the use of existing facilities:

- The current unmet demand for mental health and substance abuse treatment services can likely be met via the improved utilization of existing resources in local and regional jails, and in DMHMRSAS facilities, rather then by the dedication of currently unused sites to that purpose.
- The fact that large local and regional jails are able to provide specialized treatment settings and programs for those with mental illness and substance abuse disorders suggests that use of such facilities as regional "nodes" for jail-based treatment of inmates requiring such care could help to alleviate the inherent difficulties of providing such services in the smaller local facilities.
- The establishment of a regionalized network of jail-based treatment programs could alleviate shortages of hospital beds needed for the treatment of acute or complex cases. These programs could provide sub-acute and extended care for inmates from throughout the region served by the jail.
- Establishment of regional dedicated MH/SA programs for inmates referred from local jails may be a more cost effective and expeditious approach to providing some of the treatment services that have traditionally been available only in psychiatric hospitals.

- ***Recommendations:***

It was the consensus of the work group that the following actions should be taken, in response to the findings summarized above:

1. The viability of providing regional jails with the resources and capacity to develop specialized units or "treatment areas" that provide comprehensive, jail-based treatment services for inmates with mental illness and substance abuse disorders should be assessed.
2. The development of such regionalized facilities would allow for the same level of mental health and substance abuse treatment services to be provided to all inmates within the operational region of the jail, despite a lack of availability of resources on the local level.
3. There is a need for a consortium or task force of criminal justice, mental health, and substance abuse service providers to be formed, to examine the options available for the enhancement of service provision to jail inmates via the use of regionalized or other approaches.

- ***Estimated fiscal impact:***

If further study of the viability of using dedicated units or areas of regional jails as settings for the provision of mental health and substance abuse treatment services to jail inmates results in a recommendation to do so, there would be an obvious need for additional resource allocation to such jails for that purpose. Given the relative savings involved with provision of treatment services in jails, rather than in hospitals, as well as the savings in additional staff coverage at local jails for the management of inmates with active symptoms of mental illness, the initial costs of establishing and operating such regionalized and jail-based programs would result in significant savings overall, throughout the system of jails and hospitals that serves individuals with mental illness and substance abuse disorders.

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